South Carolina Department of Disabilities & Special Needs
Contract Compliance Review Tool (All Services)

ADMINISTRATIVE INDICATORS & GUIDANCE

Review Year July 2018 through June 2019

Shaded indicators represent data collected for Waiver Evidentiary Reports or Home and Community Based Services Transition Plan Reporting.

A1	**Administrative / Operational Issues** *A1 indicators are scored met/ not met.*	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
A1-01	For those for whom outlier status has been approved due to the need for enhanced staff support, the Board / Provider provides the additional support as outlined in the approved request.	250-11-DD requires that residential service providers must retain staff schedules that document the increased level of supervision is being provided. The QIO will verify the presence of additional staffing support as well as other supports (i.e., Behavior Support Plan and training [Habilitation] strategies) that are needed in order to decrease the need for outlier funding. Source: MOA DDSN/HHS, 250-11-DD
A1-02	For those for whom outlier status has been approved due to the need for 1:1 staff support, the Board / Provider provides the additional support as outlined in the approved request.	At the end of each shift that 1:1 Supervision was provided the direct care staff assigned to provide the 1:1 supervision must document that the 1:1 supervision was provided. The QIO will verify the presence of additional staffing support as well as other supports (i.e., Behavior Support Plan and training [Habilitation] strategies) that are needed in order to decrease the need for outlier funding. Source: MOA DDSN/DHHS, 250-11-DD
A1-03	The Board / Provider has a Human Rights Committee that is composed of a minimum of 5 members and includes representation from a family member of a person receiving services, a person representing those receiving services or a self-advocate nominated by the local self-advocacy group, and a representative of the community with expertise or a demonstrated interest in the care and treatment of persons (employees or former employees must not be appointed). The Board/ Provider has a Human Rights Committee member list (which identifies the above), along with an attendance log for each Human Rights Committee meeting.	South Carolina Code Ann. 44-26-70 requires that each DDSN Regional Center and DSN Board establish a Human Rights Committee. Contract service providers may either use the Human Rights Committee of the local DSN Board or establish their own Committee. Contract providers must have formal documentation of this relationship. Source: South Carolina Code Ann. 44-26-70 and 535-02-DD
A1-04	The Human Rights Committee will provide review of Board / Provider practices to assure that consumer's due process rights are protected.	Minutes shall be taken of each meeting and shall reflect the date and time of the meeting, those Committee members present and absent, and a record of decisions and recommendations in a manner that readily identifies the issues reviewed, the decisions reached, and the follow-up that is necessary. In addition to reviewing Behavior Support Plans and Psychotropic Medications, the provider must document the HRC's review of any use of emergency restraints. The

		HRC must also receive notification of alleged abuse, neglect, or exploitation. Each Human Rights Committee, in coordination with the Agency, may establish its own mechanism to receive such reports. The HRC should also advise the DSN Board or contract provider agency on other matters pertaining to the rights of people receiving services and other issues identified by the Human Rights Committee or Agency. The sharing of this information and related discussion must be documented in the HRC meeting minutes. Source: 535-02-DD
A1-05	Board / Provider implements a risk management and quality assurance program consistent with 100-26-DD and 100-28-DD.	Board / Provider demonstrates implementation of risk management/quality assurance principles and signed, dated minutes from the Risk Management Committee quarterly reviews through the following measures: • designated risk manager and a risk management committee • written policies/procedures used to collect, analyze and act on risk data • documentation of remediation taken; • correlating risk management activities with quality assurance activities; • developing contingency plans to continue services in the event of an emergency or the inability of a service provider to deliver services. • For residential and day service providers: Review of medication errors and remediation (if not conducted through a separate committee for this purpose, documentation must be available). • For residential and day service providers: Review of any restraints or restrictive procedures used to ensure compliance with applicable directives. • Review of any GERD/ Dysphagia Consultation reports to ensure there has been follow-up on recommendations. Source: 100-26-DD and 100-28-DD
A1-06	Board / Provider demonstrates usage of the current incident management profile data report to: • evaluate provider specific trends over time • evaluate/explain why the provider specific rate is over, under or at the statewide average • demonstrate systemic actions to prevent future incidents/ allegations.	Provider must utilize data available within the DDSN Incident Management System and Therap GER provider reports for the prior 12 month period. In the event the provider has not had any reports of incidents, they must document the review of trend data and discuss continued actions to prevent incidents and respond where appropriate.
A1-07	The Board / Provider follows SCDDSN procedures regarding Medication Error/ Event Reporting, as outlined in 100-29-DD.	For DDSN Residential and Day Services Providers: Determine if the Board / Provider has developed an internal database to record, track, analyze, and trend medication errors or events associated with the administration of medication errors. The method for calculating medication error rate has been defined in DDSN Directive 100-29-DD. Source: 100-29-DD

A1-08	The Board/ Provider utilizes an approved curriculum or system for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations.	*Not Applicable to Case Management Providers Source: 567-04-DD
A1- 09	Upper level management staff of the Board/Provider conduct quarterly unannounced visits to all residential settings to assure sufficient staffing and supervision are provided. Documentation of the visit must include the date and time of the visit, the names of the staff/caregivers and consumers present, notation of any concerns and actions taken in response to noted concerns.	When a residential setting does not utilize a shift model for staffing (e.g. CTH I and SLPI) visits need only to be conducted quarterly. The Provider shall conduct quarterly unannounced visits to all of its residential locations across all shifts excluding third shift in Community Training Home I and Supervised Living I Programs, including weekends, to assure sufficient staffing and supervision per the consumers' plans. Managers should not visit homes they supervise but should visit homes managed by their peers. Senior management may visit any/all of the homes. Documentation of the visit must include the date and time of the visit, the names of the staff/caregivers and consumers present, notation of any concerns and actions taken in response to noted concerns. SLP II should include visits to all apartments. **Please note**: It is not necessary to visit individual SLP II apartments, during 3rd shift, although 3rd shift checks to the complex/staff review are still required. CIRS and CTH I locations do not require unannounced 3rd shift checks. *Quarterly = 4 times per year with no more than 4 months between visits. Source: Contract…Capitated Model Article III
A1- 10	The Board / Provider /Intake Provider keeps service recipients' records secure and information confidential.	Source: 167-06-DD
A1- 11	The Provider agency of HASCI Division Rehabilitation Supports (RS) maintains required administrative records for the RS Program.	Source: Rehabilitation Supports Manual
A1- 12	Board/Provider conducts all residential admissions/discharges in accordance with 502-01-DD.	Source: 502-01-DD
A1-13	Case Management providers must have a system that allows access to assistance 24 hours daily, 7 days a week.	Source: SCDDSN Case Management Standards
A1- 14	The Residential Habilitation provider must have procedures that specify the actions to be taken to assure that <u>within 24 hours</u> following a visit to a physician, Certified Nurse Practitioner (CNP), or Physician's Assistant (PA), all ordered treatments will be provided. The procedures must include the specific steps to be taken and by whom. The procedures must be current.	Source: Residential Habilitation Standards
A1- 15	The Board/ Provider follows procedures regarding Medication Technician Certification program, as outlined in 603-13-DD.	Source: 603-13-DD
A1- 16	The Provider demonstrates agency-wide usage of Therap for the maintenance of Case Management records according to the implementation schedule approved by DDSN.	Source: DDSN Therap Requirements

A1- 17	The Provider demonstrates agency-wide usage of Therap for the maintenance of Residential Services records according to the implementation schedule approved by DDSN.	Source: DDSN Therap Requirements
A1- 18	The Provider demonstrates agency-wide usage of Therap for the maintenance of Day Services records according to the implementation schedule approved by DDSN.	Source: DDSN Therap Requirements
A1-19	The Provider demonstrates agency-wide usage of Therap for the maintenance of Intake records according to the implementation schedule approved by DDSN.	Source: DDSN Therap Requirements
A1-20	The Provider demonstrates agency-wide usage of Therap for General Event Reports (GERs) according to the implementation schedule approved by DDSN.	*Applies to Day and Residential Services only. Source: DDSN Therap Requirements
A2	**Fiscal Issues** *A2 indicators are scored met/ not met.*	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
A2-01	The Governing Board approves the annual budget and Comprehensive Financial Reports are presented at least quarterly to the Governing Board with a comparison to the approved budget.	Source: Contract for …Capitated Model and Contract for Non-Capitated Model
A2-02	An Annual Audit Report is presented to Governing Board once a year and includes the written management letter. [Board Providers Only]	Source: 275-04-DD
A2-03	The person's financial responsibility is made known to them by the Board / Provider. [All Residential Providers]	Source: 200-12-DD
A3	**Staff Qualifications, Training, and Reporting Requirements** *A3 Indicators are scored based on the percentage of compliant files reviewed.*	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
A3-01	The Board / Provider employs Intake Staff who meet the minimum education requirements for the position.	Source: DDSN Intake Standards
A3-02	The Board / Provider employs Intake Staff who meet the criminal background check requirements for the position.	Source: DDSN Intake Standards, DDSN Directive 406-04-DD
A3-03	The Board / Provider employs Intake Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.	Source: DDSN Intake Standards, DDSN Directive 406-04-DD
A3-04	The Board /Provider employs Intake Staff who meet the DSS Central Registry check requirements for the position.	Source: DDSN Intake Standards, DDSN Directive 406-04-DD
A3-05	The Board /Provider employs Intake Staff who meet the Sex Offender Registry check requirements for the position.	Source: DDSN Intake Standards
A3-06	The Board /Provider employs Intake Staff who meet the TB Testing requirements for the position.	Source: DDSN Intake Standards, DDSN Directive 603-06-DD
A3-07	The Board / Provider employs Case Management Staff who meet the minimum education requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Refer to SCDDSN Case Management Standards for educational, vocational and credentialing requirements.
A3-08	The Board / Provider employs Case Management Staff who meet the criminal background check requirements to provide Medicaid Targeted Case Management and DDSN State	Source: DDSN Case Management Standards, DDSN Directive 406-04-DD

	Funded Case Management.	
A3-09	The Board / Provider employs Case Management Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Source: DDSN Case Management Standards, DDSN Directive 406-04-DD
A3-10	The Board /Provider employs Case Management Staff who meet the DSS Central Registry check requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Source: DDSN Case Management Standards, DDSN Directive 406-04-DD
A3-11	The Board /Provider employs Case Management Staff who meet the Sex Offender Registry check requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Source: DDSN Case Management Standards
A3-12	The Board /Provider employs Case Management Staff who meet the TB Testing requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Source: DDSN Case Management Standards DDSN Directive 603-06-DD
A3-13	The Board /Provider employs Case Management Staff with acceptable reference check requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Source: DDSN Case Management Standards DDSN Directive 406-04-DD
A3-14	The Board /Provider employs Early Intervention Staff who meet the minimum education requirements for the position.	See Early Intervention Manual for educational, vocational and credentialing requirements.
A3-15	The Board /Provider employs Early Intervention Staff who meet the criminal background check requirements for the position.	Source: EI Manual, DDSN Directive 406-04-DD
A3-16	The Board /Provider employs Early Intervention Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.	Source: EI Manual, DDSN Directive 406-04-DD
A3-17	The Board /Provider employs Early Intervention Staff who meet the DSS Central Registry check requirements for the position.	Source: EI Manual, DDSN Directive 406-04-DD
A3-18	The Board /Provider employs Early Intervention Staff who meet the TB Testing requirements for the position.	Source: EI Manual, DDSN Directive 603-06-DD
A3-19	The Board /Provider employs Early Intervention Staff with acceptable reference check requirements for the position.	Source: EI Manual, DDSN Directive 406-04-DD
A3-20 R	**The Board /Provider employs Waiver Case Management Staff who meet the education requirements for the position.**	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements.
A3-21 R	**The Board /Provider employs Waiver Case Management Staff who meet the criminal background check requirements for the position.**	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements and DDSN Directive 406-04-DD.
A3-22 R	**The Board /Provider employs Waiver Case Management Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.**	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements and DDSN Directive 406-04-DD.

A3-23 R	**The Board /Provider employs Waiver Case Management Staff who meet the DSS Registry check requirements for the position.**	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements and DDSN Directive 406-04-DD.
A3-24 R	**The Board /Provider employs Waiver Case Management Staff who meet the Sex Offender Registry check requirements for the position.**	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements.
A3-25 R	**The Board /Provider employs Waiver Case Management Staff who meet the TB Testing requirements for the position.**	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements and DDSN Directive 603-06-DD.
A3-26	The Board /Provider employs Waiver Case Management Staff with acceptable reference check requirements for the position.	Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements and DDSN Directive 406-04-DD.
A3-27 R	**The Board /Provider employs Residential Staff who meet the minimum education requirements for the position.**	Refer to SCDDSN Residential Habilitation Standards for educational and vocational requirements for all staff including those providing Intensive Behavioral Intervention (Residential Habilitation Standard 7.7).
A3-28 R	**The Board /Provider employs Residential Staff who meet the criminal background check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-29 R	**The Board /Provider employs Residential Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-30 R	**The Board /Provider employs Residential Staff who meet the DSS Central Registry check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-31 R	**The Board /Provider employs Residential Staff who meet the TB Testing requirements for the position.**	Source: DDSN Directive 603-06-DD
A3-32	The Board /Provider employs Residential Staff with acceptable reference check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-33 R	**The Board /Provider employs Day Services Staff who meet the minimum education requirements for the position.**	Refer to SCDDSN Day Services Standards for educational and vocational requirements.
A3-34 R	**The Board /Provider employs Day Services Staff who meet the criminal background check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-35 R	**The Board /Provider employs Day Services Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-36 R	**The Board /Provider employs Day Services Staff who meet the DSS Central Registry check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-37 R	**The Board /Provider employs Day Services Staff who meet the TB Testing requirements for the position.**	Source: DDSN Directive 603-06-DD
A3-38	The Board / Provider employs Day Services Staff with acceptable reference check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-39 R	**The Board / Provider employs/ contracts Respite/ In-Home Support staff who meet the minimum education requirements for the position.**	Agencies that are contracted will be reviewed separately.

A3-40 R	**The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the criminal background check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-41 R	**The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-42 R	**The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the DSS Central Registry check requirements for the position.**	Source: DDSN Directive 406-04-DD
A3-43 R	**The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the TB Testing requirements for the position.**	Source: DDSN Directive 603-06-DD
A3-44	The Board / Provider employs/ contracts Respite/ In-Home Support Staff with acceptable reference check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-45	Case Managers who provide MTCM or SFCM receive ANE training as required.	Source: DDSN Case Management Standards and DDSN Directive 534-02-DD
A3-46	Case Managers who provide MTCM or SFCM receive training as required.	Source: DDSN Case Management Standards and DDSN Directive 567-01-DD
A3-47 R	**Waiver Case Management Staff receive ANE training as required.**	Source: DDSN Directive 534-02-DD
A3-48 R	**Waiver Case Management Staff receive training as required.**	WCMs are required to receive twenty (20) hours of training annually. Training must include the following topic areas: • Confidentiality • Annual Level of Care for NF and ICF/IID • Service Authorizations/ Terminations • Waiver Participant Disenrollment Source: DDSN Directive 567-01-DD
A3-49	Early Intervention staff receive ANE raining as required.	Source: Early Intervention Standards and DDSN Directive 534-02-DD
A3-50	Early Intervention staff receive training as required.	Source: Early Intervention Standards and DDSN Directive 567-01-DD
A3-51	Residential staff receive ANE training as required.	Source: Residential Habilitation Standards and DDSN Directive 534-02-DD
A3-52	Residential staff receive training as required.	Source: Residential Habilitation Standards and DDSN Directive 567-01-DD
A3-53	Day Services staff receive ANE training as required.	Source: Day Services Standards and DDSN Directive 534-02-DD
A3-54	Day Services staff receive training as required.	Source: Day Services Standards and DDSN Directive 567-01-DD
A3-55	Respite/ In-Home Supports staff/ contractors receive ANE training as required.	Note: The indicator will be scored using the number of compliant files/ the total number of files reviewed for this indicator. Source: DDSN Directive 534-02-DD
A3-56	Respite/ In-Home Supports staff/ contractors receive training as required.	Refer to DDSN Directive 567-01-DD

A3-57	Annually, employees are made aware of the False Claims Recovery Act, that the Federal government can impose a penalty for false claims, that abuse of the Medicaid Program can be reported and that reporters are covered by Whistleblowers' laws.	Source: Contract for … Capitated Model and Source: Contract for … Non-Capitated Model
A3-58	Board / Provider follows SCDDSN procedures for submitting initial reports for allegations of abuse / neglect / exploitation as outlined in 534-02-DD.	Source: DDSN Directive 534-02-DD
A3-59	Board / Provider follows SCDDSN procedures for submitting internal final reports for allegations of abuse / neglect / exploitation as outlined in 534-02-DD.	Source: DDSN Directive 534-02-DD
A3-60	Board / Provider follows SCDDSN procedures for submitting initial critical incident reports as outlined in 100-09-DD.	Source: DDSN Directive 100-09-DD
A3-61	Board / Provider follows SCDDSN procedures for submitting internal final critical incident reports as outlined in 100-09-DD.	Source: DDSN Directive 100-09-DD
A3-62	Board / Provider follows SCDDSN procedures for submitting initial reports of death or impending death as outlined in 505-02-DD.	Source: DDSN Directive 505-02-DD
A3-63	Board / Provider follows SCDDSN procedures for submitting internal final reports of death or impending death as outlined in 505-02-DD.	Source: DDSN Directive 505-02-DD
A3-64	The "Swallowing Disorders Checklist" is completed annually.	Annual completion of the Swallowing Disorders Checklist is required for individuals receiving residential services. Staff can use the checklist for an individual receiving day services if there is an ongoing concern. The protocol must be completed for any choking incident that occurs while at the Day Program. Source: 535-13-DD
A3-65	If a critical incident due to choking (with airway obstruction) occurred or if a non-obstructing choking incident occurred, "yes" responses were noted on the "Swallowing Disorders Checklist" and the "Swallowing Disorders Follow-Up Assessment" was completed not more than five business days after the incident and submitted to DDSN for review.	Source: 535-13-DD
A3-66	If "yes" was noted as a response to any item (other than choking) on the "Swallowing Disorders Checklist", the "Swallowing Disorders Follow-Up Assessment" was completed and submitted with the "Checklist" to DDSN for review, not more than ten business days after responding "yes" to an item on the "Checklist".	Source: 535-13-DD
A3-67	All actions/recommendations included in "Required Provider Follow-Up" on the Swallowing Disorders Consultation Summary, were added to the person's plan (residential, day services or case management) and implemented within 30 calendar days or reason for non-implementation was documented.	The person's Plan (residential, day services or case management) should be amended to include any actions/recommendations noted in "Required Provider Follow-Up" resulting from the review of the "Checklist" and the "Assessment". All actions/recommendations noted in "Required Provider Follow-Up" must be implemented within 30 calendar days or there must be written justification for non-implementation. Source: 535-13-DD

SERVICE AREA INDICATORS & GUIDANCE

Review Year July 2018 through June 2019

IN	Intake/ Operational Issues	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
IN-01	Contact with the Intake service user is made within five (5) business days of the receipt of an authorization for Intake or reflects more than one (1) attempt to contact within five (5) business days.	Source: Intake Standards
IN-02	Documentation includes sufficient information to prove that a thorough explanation of the following was provided to the service user or his/her representative: • The process for Intake including next steps, • DDSN as an agency and how services through DDSN are provided; • Services potentially available through DDSN is determined eligible for services, including the criteria to be met in order for services to be authorized.	Source: Intake Standards
IN-03	Intake activities are documented within five (5) business days of the occurrence of the activity.	Source: Intake Standards
IN-04	Contact with or on behalf of the service user occurred, at a minimum, every ten (10) business days.	Source: Intake Standards
IN-05	If terminated, Intake was only terminated when, during a thirty (30) calendar day period, at least three (3) consecutive attempts to contact the service user/ representative were unsuccessful or by request from the individual who is going through the Intake Process.	Source: Intake Standards
CM	**Case Management**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
CM-01	The person's file contains either an Authorization Letter from SCDHHS for MTCM or approval from DDSN for State Funded Case Management dated on or prior to the first reported case management activity.	This indicator is applicable for services starting on or after May 1, 2014. For services starting prior to May 1, 2014 – Form 259 (transition form) must be present in the person's file. A valid precertification date range on CDSS is acceptable documentation for approval of SFCM. Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-02	The person's file contains documentation that establishes the person in a target group, if receiving MTCM.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-03	The person's file contains an appropriately signed Freedom of Choice for MTCM form, if receiving MTCM.	Prior to May 1, 2014, the Freedom of Choice for MTCM form may indicate "DDSN" as the chosen provider. For forms signed after May 1, 2014, the Case Management provider agency's name should be noted as the chosen provider.

		Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-04	A valid Service Agreement is present and signed as appropriate.	Source: SCDDSN Case Management Standards Applies ONLY for Non-Waiver consumers
CM-05	An assessment of the person's needs is completed.	Source: SCDDSN Case Management Standards Applies ONLY for Non-Waiver consumers
CM-06	A face to face contact with the person in his/her residence is made at the time of initial/ annual assessment.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-07	A plan addressing the person's assessed needs is completed.	Source: SCDDSN Case Management Standards Applies ONLY for Non-Waiver consumers
CM-08	The plan contains all required components.	Source: SCDDSN Case Management Standards Applies ONLY for Non-Waiver consumers
CM-09	The plan is signed, titled and dated by the Case Manager.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-10	The plan is signed by the person or his/her representative.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-11	The person must be provided a copy of the plan.	Source: SCDDSN Case Management Standards Applies ONLY to Non-Waiver consumers
CM-12	Annually, people are provided information about abuse, neglect and exploitation and information about critical incidents.	Source: SCDDSN Case Management Standards Applies ONLY for Non-Waiver consumers
CM-13	Contact (face-to-face, email or telephone) is made with the person, his/her family or representative or a provider who provides a service to the person at least every 60 days.	Source: SCDDSN Case Management Standards Applies ONLY for Non-Waiver consumers
CM-14	The Case Management Assessment and Plan must be reviewed at least 180 days from the Date of the Plan.	Source: SCDDSN Case Management Standards Score ONLY for Non-Waiver consumers
CM-15	The 180 Day Plan Review must be completed in consultation with the person/his/her representative. Consultation must include a face-to-face visit in the person's natural environment.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-16	Service notes must document all Case Management activity on behalf of the person and justify the need for Case Management.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
CM-17	Services notes are appropriately documented.	Source: SCDDSN Case Management Standards Applies to Waiver and Non-Waiver consumers
WA	**Waiver Activities**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
WA-01 R	**The Plan is developed as required.**	Source: Support Plan Instructions, Waiver Manual
WA-02 R	**The plan includes Waiver service(s) name, frequency of the service(s), amount of service(s), duration of service(s), and valid provider type for service(s).**	Due to the SCDDSN Waiver Administration Division entering plan information, after 10/30/17, SCDDSN will be held responsible for recoupment and citation of this indicator. This indicator will not be calculated in the provider score. Data will be collected for Waiver Evidentiary Reporting only. Source: Waiver Manual

WA-03 W	Service needs outside the scope of Waiver services are identified in Plans and addressed.	Source: Waiver Manual
WA-04	Needs in the Plan are justified by formal or informal assessment information in the record.	Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, Waiver Manual pertaining to needs assessment.
WA-05	Assessment(s) justify the need for all Waiver services included on the plan.	Source: Waiver Manual
WA-06	Services/ Interventions are appropriate to meet assessed needs.	Source: Waiver Manual
WA-07 R	**The Plan identifies appropriate funding sources for services/interventions.**	Due to the SCDDSN Waiver Administration Division entering plan information, after 10/30/17, SCDDSN will be held responsible for recoupment and citation of this indicator. This indicator will not be calculated in the provider score. Data will be collected for Waiver Evidentiary Reporting only. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* for defined resources, Waiver Manual
WA-08	The Plan is provided to the participant/ representative.	Source: Waiver Manual
WA-09 R	**The Plan is amended / updated as needed.**	Source: Support Plan Instructions and Waiver Manual.
WA-10 W	Contact occurs as required: a) Face-to-face contacts occur every 180 days b) Every 60 days, at least one contact (as defined by CM Standards) is made.	Source: Case Management Standards
WA-11	The Plan is reviewed at least every 180 days.	Refer to Case Management Standards and Support Plan Instructions
WA-12	A valid Service Agreement is present and signed as appropriate.	Source: Waiver Manual
WA-13	The person/legal guardian (if applicable) will receive information on abuse and neglect annually.	Source: Waiver Manual
WA-14 R	**For ID/RD and CS Waiver – At the time of annual planning, all children enrolled in the ID/RD and CS Waiver receiving CPCA services must have a newly completed physician's order (Physician's Information Form – MSP Form 1), and assessment (SCDDSN Personal Care/Attendant Care Assessment). Physician's order and assessment are required annually.**	See MSP forms/attachments in the CPA section of the ID/RD and CS Waiver Manuals.
WA-15	For ID/RD and CS Waiver – If a child is assessed to need over 10 hours of Children's PCA services per week, DDSN prior authorization is obtained.	Source: Waiver Manual
WA-16	For ID/RD and CS Waiver – If a child receives CPCA services, the Service Needs Requirement and, unless otherwise specified, a Functional deficit exists (check only for those receiving 10 hours or less of CPCA services).	Look for the CPCA Assessment – it gives information to determine if at least one functional deficit is present.

WA-17 W	Documentation is present verifying that a choice of provider was offered to the participant/ family for each new Waiver service.	Source: Waiver Manual
WA-18	The Freedom of Choice Form is present.	Source: Waiver Manual
WA-19	The Initial Level of Care is present.	Review the initial LOC determination to verify it was completed within 30 days prior to or on the date of Waiver enrollment.
WA-20 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care determination and is completed by the appropriate entity.**	Source: Waiver Manual
WA-21 R	**The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination.**	Source: Waiver Manual
WA-22 R	**The Current Level of Care is completed appropriately.**	Source: Waiver Manual
WA-23	For HASCI – The Acknowledgement of Choice and Appeal Rights Form completed prior to Waiver enrollment and annually.	If participant was a competent adult at time of Waiver initial enrollment or re-enrollment, but physically unable to sign, both the form and a Service Note should indicate why participant's signature was not obtained. Source: Waiver Manual
WA-24	Acknowledgement of Rights and Responsibilities is completed annually. For HASCI - Acknowledgement of Rights and Responsibilities is completed prior to enrollment.	This form is not required annually for HASCI. Source: Waiver Manual
WA-25	Waiver services are provided in accordance with the service definitions found in the Waiver document.	Source: Waiver Manual
WA-26 R	**For ID/RD and HASCI Waiver – If Nursing Services are provided, an order from the physician is present and is consistent with the authorization form.**	Source: Waiver Manual
WA-27	Waiver services are received at least every 30 calendar days. For HASCI – one waiver service is received per calendar month.	Source: Waiver Manual
WA-28 R	**Authorization forms are properly completed for services as required, prior to service provision.**	Source: Waiver Manual
WA-29 R	**Authorized waiver services are suspended when the waiver participant is hospitalized, or temporarily placed in an NF or ICF/IID.**	NOTE: Not intended for Institutional Respite cases.
WA-30 R	**Waiver termination is properly completed.**	Source: Waiver Manual
WA-31 R	**The Participant/Legal Guardian (if applicable) was notified in writing regarding any denial, termination, reduction, or suspension of Waiver services with accompanying reconsideration/appeals information.**	Not required in the case of death. Source: Waiver Manual
WA-32	For ID/RD and CS Waiver – Information including the benefits and risks of participant/ representative directed care is provided to the participant/ representative prior to the authorization of Adult Attendant Care.	Source: Waiver Manual

WA-33	For ID/RD and CS Waiver – Before authorization of Adult Attendant Care Services, the absence of cognitive deficits in the participant/ representative that would preclude the use of participant/ representative directed care is assessed and documented.	Source: Waiver Manual
WA-34	For ID/RD and CS Waiver – Before authorization of Adult Attendant Care Services, the participant/ representative is provided information about hiring management and termination of workers as well as the role of the Financial Management System is provided to the participant/ representative.	Source: Waiver Manual
WA-35	For HASCI Waiver – The risks associated with refusing a Waiver service have been identified and documented.	Source: HASCI Waiver Manual
WA-36	For HASCI Waiver – The unavailability of a Waiver service provider is documented and actively addressed.	Source: HASCI Waiver Manual
WA-37	For HASCI Waiver – Copies of Daily Logs for Self-Directed Attendant Care are received and the service is monitored.	Source: HASCI Waiver Manual
WA-38	Applies to all waivers. Effective 7/1/18, for individuals awarded a waiver slot within the review period, the waiver enrollment timeline was followed to receive the Freedom of Choice or the Waiver Declination form or to follow the Waiver Non-Signature Declination process.	Source: Waiver Manual
WA-39	Applies to all waivers. Effective 7/1/18, for individuals awarded a waiver slot within the review period, the waiver enrollment timeline was followed to request the Level of Care or to follow the Waiver Non-signature Declination process.	Source: Waiver Manual
WA-40	Applies to all waivers. Effective 7/1/18, for individuals awarded a waiver slot within the review period, the waiver enrollment timeline was completed to get the individual enrolled in the waiver.	Source: Waiver Manual
WCM	**Waiver Case Management Activities**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
WCM-01 R	**For newly enrolled waiver participants, the first non-face-to-face contact is completed within 30 days of waiver enrollment.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-02 R	**For newly enrolled waiver participants, the first quarterly face-to-face visit is completed within 90 days of waiver enrollment.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-03 R	**Each month, except during the months when required quarterly face-to face visits are completed, a non-face-to-face contact is made with the participant or his/her representative.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-04 R	**Non-face-to-face contact is appropriately documented in services notes.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-05 R	**A minimum of four (4) quarterly face-to-face visits are made with the participant/family each plan year.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-06	**Two of the four (4) quarterly face-to-face visits with the participant/family are conducted in the**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*

R	**participant's residence and are conducted every other quarter of the plan year.**	
WCM-07 R	**Quarterly face-to-face visits are appropriately documented.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-08	Participants receive two (2) waiver services every thirty (30) days.	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-09 R	**When contacts (other than the required monthly contacts and required quarterly face-to-face contacts) are made or activities are conducted, the contact/activity is appropriately documented.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-10	Contacts (other than the required monthly contact and required quarterly face-to-face contact) are recorded as NON- REPORTABLE on CDSS if the required monthly contact and/or quarterly face-to-face visit has not been completed during the month/quarter with the participant/family member, or if the required monthly contact/quarterly visit is not documented in the participant's record within seven (7) calendar days of completion.	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
WCM-11 R	**Service notes intended to document Waiver Case Management activities are sufficient in content to support Medicaid billing.**	*(DDSN will announce dates of applicability- Currently not included in Contract Compliance Reviews)*
HRS	**HASCI Division Rehabilitation Supports**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
HRS-01	The RS Record contains a valid Medical Necessity Statement (MNS).	Source Document: Rehabilitation Supports Manual
HRS-02	The RS Record documents a comprehensive assessment of needs and strengths to guide development or update of an IPOC.	Source Document: Rehabilitation Supports Manual
HRS-03	The RS Record contains a valid Individual Plan of Care (IPOC).	Source Document: Rehabilitation Supports Manual
HRS-04	The RS Record contains 90 Day Progress Reviews of the IPOC.	Source Document: Rehabilitation Supports Manual
HRS-05	The RS Record contains a Rehabilitation Supports Summary Note for each day that RS were received.	Source Document: Rehabilitation Supports Manual
HRS-06	The RS Record contains a Rehabilitation Supports Monthly Progress Summary for each month RS were received.	Source Document: Rehabilitation Supports Manual
HRS-07	The RS service provision billed to SCDDSN is substantiated in the RS Record.	Source Document: Rehabilitation Supports Manual
PDD	**Pervasive Developmental Disorder Waiver**	Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.
PDD-01 R	PDD Waiver participants must meet all eligibility criteria.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-02	**Not reviewed effective January 1, 2018** The Freedom of Choice Form is present for PDD Waiver recipients.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-03	**Not reviewed effective January 1, 2018** The Initial Level of Care is present.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-04	Case Managers are responsible for preparing and submitting all documents needed for	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual

R	timely determination of the ICF/IID LOC by the Consumer Assessment Team. The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the Consumer Assessment Team.	
PDD-05 W	**Not reviewed effective January 1, 2018** Documentation is present verifying that a choice of providers was offered to the child's parents/legal guardians for each PDD service.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-06	**Not reviewed effective January 1, 2018** The Acknowledgement of Rights and Responsibilities is completed annually.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-07	**Not reviewed effective January 1, 2018** PDD services are provided in accordance with the service definitions.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-08	**Not reviewed effective January 1, 2018** For PDD Waiver recipients, PDD Waiver services are received at least every 30 days.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-09 R	Authorization forms are completed prior to service provision and match the identified needs in the support plan.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-10 R	The Person/Legal Guardian was notified in writing regarding any, suspension, denial or termination of PDD services with accompanying reconsideration and appeals information.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-11 R	The Plan clearly includes and justifies the need for all PDD Waiver services received.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-12 R	The Plan is amended/ updated as needed.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-13	**Not reviewed effective January 1, 2018** The record must reflect that the child's parent/legal guardian was offered the opportunity to participate in planning.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-14	**Not reviewed effective January 1, 2018** The parent/legal guardian was provided a copy of the Plan.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-15 R	Case Managers who serve children in the PDD Program must meet the minimum requirements for the position.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-16 R	Records include documentation of verification that Case Managers are free from tuberculosis.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-17	**Not reviewed effective January 1, 2018** Case Managers will provide at least 1 monthly contact with the EIBI service providers and/or family to determine progress/lack of progress on established goals and/or person satisfaction with EIBI providers.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-18	**Not reviewed effective January 1, 2018** Case Managers will contact the child's family quarterly.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-19 W	**Not reviewed effective January 1, 2018** Case Managers will have at least one face-to-face contact visit with the child and their family annually.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual

PDD-20 R	Case Managers will ensure the Plan is developed, reviewed and approved within every 365 days or more often if needed.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-21	**Not reviewed effective January 1, 2018** Case Managers must document all activities in the child's record.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-22	**Not reviewed effective January 1, 2018** Case Managers must document the date on which the child's referral was first received and the date all actions taken thereafter.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-23	**Not reviewed effective January 1, 2018** Case record documentation must reflect that the child's parents were given information on all EIBI qualified providers in the State and given guidance on which providers are in close proximity to the parent/legal guardian's community.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-24	**Not reviewed effective January 1, 2018** Case Managers must utilize required forms, completed properly, and they must include the required signatures.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-25	**Not reviewed effective January 1, 2018** Case Manager's must assure, and records must reflect that each child's parent has been provided with information about how to file a complaint.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-26	**Not reviewed effective January 1, 2018** Case Managers are required to attend at least one in-service training annually related to autism and the provision of case management to individuals enrolled in the PDD Waiver. The training must be facilitated by the Autism Division.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-27 W	**Not reviewed effective January 1, 2018** Case Management records are maintained and include required information.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-28 R	Waiver termination properly completed.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
PDD-29 R	Authorized waiver services are suspended when the waiver participant is hospitalized or temporarily placed in an NF or ICF/IID.	Source: PDD Waiver Manual, DDSN Directives & Standards, and DHHS Provider Manual
RS1	**Residential/ Health Services**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
RS1-01 R	**The Residential Support Plan must include:** **a) The type and frequency of care to be provided** **b) The type and frequency of supervision to be provided** **c) The functional skills training to be provided** **d) Any other supports/interventions to be provided** **e) Description of how each intervention will be documented.**	Source: Residential Habilitation Standards
RS1-02 R	**A comprehensive functional assessment:** **A. Is completed prior to the development of the initial plan** **B. Is updated as needed to insure accuracy.**	The assessment does not have to be re-done annually. It is acceptable to review the assessment and indicate the date of review and the fact that the assessment remains current and valid. This

		notation must be signed or initialed by the staff that completed the review. Source: Residential Habilitation Standards
RS1-03 R	**Within 30 days of admission and within every 365 days thereafter, a residential plan is developed:** **a) that supports the person to live the way he/she wants to live** **b) that reflects balance between self-determination and health and safety** **c) that reflects the interventions to be applied.**	Source: Residential Habilitation Standards
RS1-04	The Plan must include: a) The goals of the person related to Residential Habilitation b) The functional skills training to be provided.	Source: Residential Habilitation Standards
RS1-05 R	**The effectiveness of the residential plan is monitored and the plan is amended when:** **a) No progress is noted on an intervention** **b) new intervention, strategy, training, or support is identified; or** **c) The person is not satisfied with the intervention.**	As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the strategy must be amended, and if necessary, the Plan as well. Source: Residential Habilitation Standards
RS1-06	A quarterly report of the status of the interventions in the plan must be completed.	Source: Residential Habilitation Standards
RS1-07	People are informed of their rights, supported to learn about their rights, and supported to exercise their rights.	All people residing in CTH I, CTH II, CRCF, CIRS, SLP I and SLP II must be informed of their rights and supported to learn about and exercise their rights unless there is documentation in the file that the person is fully capable of understanding their rights and there is an assessment that confirms this. Source: Residential Habilitation Standards
RS1-08	Personal freedoms are not restricted without due process.	Due process means human rights review of any restriction. The person must be offered the opportunity to attend the HRC meeting and have someone accompany them to assist in advocating for themselves, if they so desire. Verified by Service Notes. Source: Residential Habilitation Standards, 535-02-DD
RS1-09	People are expected to manage their own funds to the extent of their capability.	Source: Residential Habilitation Standards 200-12-DD Management of Funds for Individuals
RS1-10	People who receive services are trained on what constitutes abuse and how and to whom to report.	All people who reside in CTH I, CTH II, CRCF, CIRS, SLP II and SLP I require training in what constitutes abuse and how and whom to report it unless there is documentation in the file that they are capable of reporting and there is an assessment to confirm this. Source: Residential Habilitation Standards, 534-02-DD
RS1-11	Effective 1/1/2019 -A legally enforceable agreement (lease, residency agreement or other form of written agreement) is in place for each person.	This indicator will be measured beginning 1/1/2019. Source: Residential Habilitation Standards

RS1-12	People receive a health examination by a licensed Physician, Physician's Assistant, or Certified Nurse Practitioner who determines the need for and frequency of medical care and there is documentation that the recommendations are being followed.	Source: Residential Habilitation Standards
RS1-13	People receive a dental examination by a licensed Dentist who determines the need for and frequency of dental care, and there is documentation that the Dentist's recommendations are being carried out.	A person who is edentulous may be checked by a physician. Note: If a person has refused dental care, there must be documentation of this in the file. Source: Residential Habilitation Standards
RS2	**Residential/ Behavior Support Services**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
RS2-01	Behavior(s) that pose a risk to the person, others, the environment, or that interfere with his/her ability to function in the environment are addressed.	Source: 600-05-DD
RS2-02	Prior to the development of a behavior support plan, indirect assessment including the following must be conducted: a) Record review of DDSN Support Plan and, if they exist, existing behavior support plan and supervision plan. b) Interview using the Functional Assessment Interview Form (O'Neill, et al., 2014) <u>or</u> another empirically validated functional assessment instrument - such as the QABF (Questions About Behavioral Function, Matson & Vollmer, 1995) - with two or more people who spend the most time with the person (can include the person) must include (or be supplemented by additional assessment documentation which includes) the following: 1. Description of problem behavior 2. Listing of ecological and setting events that predict the occurrence and/or non-occurrence of the behavior 3. Listing of possible antecedents that predict the occurrence and/or non-occurrence of the behavior 4. Listing of possible consequences (access, escape/avoid, automatic) that maintain the problem behavior 5. Record of information on the efficiency of the problem behavior 6. List of functional alternatives the person currently demonstrates 7. Description of the person's communication skills 8. Description of what to do and what to avoid in teaching 9. Listing of what the person likes (potential reinforcers) 10. Listing of the history of the problem behavior(s), previous interventions, and effectiveness of those efforts c) Development of summary statements based on the *Functional Assessment Interview* (contains information on setting events, antecedents, problem behavior, and consequences)	Written information in the BSP and/or assessment file indicates that each component of the assessment was conducted. a) Does the Support Plan reflect the need for behavior support services? b) A completed Functional Assessment Interview form or other empirically validated functional assessment instrument (and, if necessary, supplemental assessment documentation) containing the 10 items in section b must be available. If the QABF (or other empirically validated functional assessment interview tool) is used there must be information provided in the assessment results (via a note) that specifies where information on each component is located. c) These must be specified in the functional assessment document. Source: Residential Habilitation Standards

RS2-03	Direct Assessment must be conducted to verify the indirect assessment information. It includes: Observational data collection forms and/or observational summaries that represent <u>two or more sessions</u> using A-B-C recording in direct observation for a minimum of: (1) <u>3 or more total hours or</u> <u>(2) 20 occurrences of the target behavior(s)</u>. If no problem behavior is observed, observational information must be summarized to describe contexts that support the non- occurrence of target behavior. If observational data do not verify the indirect assessment information, then the summary statements must be revised to correspond to the direct assessment data.	A summary must be included in the functional assessment (document) that includes the relative frequency of specific antecedents and consequences for individual problem behaviors. This can be either a table or narrative format. The functional assessment is a document that can be separate from the BSP (conclusions referenced in the BSP) in the BSP. In either case, the entire functional assessment document must be available. If during observations no target behaviors are observed, either summarized A-B-C data from staff observations or conduct additional observations that do include occurrences of the target behavior(s) must be included. Source: Residential Habilitation Standards
RS2-04	Behavior Support Plans must contain: a) Description of the person: 1) Name, age, gender, residential setting, 2) Diagnoses (medical and psychiatric), 3) Intellectual and adaptive functioning, 4) Medications (medical and psychiatric), 5) Health concerns, 6) Mobility status, 7) Communication skills, 8) Daily living skills, 9) Typical activities and environments, 10) Supervision levels, 11) Preferred activities, items, and people, and 12) Non-preferred activities, items, and people. b) Locations where BSP will be implemented and identification of program implementers. c) Problem Behaviors and Replacement Behaviors in terms that are observable, measurable, and on which two independent observers can agree. d) Summary of direct assessment results. e) Objectives for each problem behavior, including: 1) Person's name, 2) Operational, measurable and observable way to describe behavior, 3) Conditions under which the behavior occurs or should occur, and 4) Criteria for completion (performance and time). f) Competing Behavior Model for each class of problem behavior that includes function of problem behavior and replacement behavior based on direct assessment	a) Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5. b) Procedures for training DSP(s) must be documented in either the BSP, training materials, or training documentation. c) Documentation of DSP training must be present to indicate training prior to the effective date / implementation date of any addendum/amendment to the BSP. Documentation must specify: 1) training on observation and behavioral data collection system and on treatment procedures, and 2) retraining on 1if needed. *Note: N/A with explanation may be acceptable* d) If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing. *Note: If N/A, then explanation is needed* If the BSP addresses more than one setting (e.g., Day Program, Home, etc.), then the fidelity check should, on a rotating basis, be conducted in each setting addressed by the plan.

	g) Objectives for each replacement behavior, including: 1) Person's name, 2) Measurable and observable way to describe behavior, 3) Conditions under which the behavior occurs or should occur, and 4) Criteria for completion (performance and time). h) Support Procedures 1) Setting Event/Antecedent Strategies 2) Teaching Strategies 3) Consequence Strategies 4) Crisis Management Strategies 5) Data Recording Method 6) Data Collection Forms	Source: Residential Habilitation Standards
RS2-05	Behavior Support Plan Implementation a) DSP(s) responsible for implementing a BSP must be fully trained to: 1) collect behavioral data, and 2) implement the BSP procedures b) Procedures for training DSP(s) on implementation must include: 1) written and verbal instruction, 2) modeling, 3) rehearsal, and 4) trainer feedback. c) Documentation of DSP(s) training must accompany the plan and must include: 1) person's name, 2) date of initial training, 3) date of additional DSP(s) training, 4) names and signatures of DSP(s) trained, and 5) name of trainer and/or authorized secondary trainer. d) Fidelity procedures must occur quarterly and must document direct observation of DSP(s) implementing procedures according to the plan. Documentation must include: a) person's name, b) name(s) of DSP(s) being observed, c) date, location and time (including duration) of observation, d) description of procedures observed, e) directions and/or description for scoring DSP performance, f) signature of observed DSP, and g) signature of the observer.	a) Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5. b) Procedures for training DSP(s) must be documented in either the BSP, training materials, or training documentation. c) Documentation of DSP training must be present to indicate training prior to the effective date / implementation date of any addendum/amendment to the BSP. Documentation must specify: 1) training on observation and behavioral data collection system and on treatment procedures, and 2) retraining on #1 if needed. *d) Note: N/A with explanation may be acceptable* e) If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing. f) *Note: If N/A, then explanation is needed* g) If the BSP addresses more than one setting (e.g., Day Program, Home, etc.), then the fidelity check should, on a rotating basis, be conducted in each setting addressed by the plan. Source: Residential Habilitation Standards
RS2-06	Progress monitoring must occur at least monthly and rely on progress summary notes that include:	Monitoring is reflected in the monthly progress note. a) Graph must be available and contain all elements. A color graph

	a) Graphs that are legible and contain: i. Title related to behavior measured, ii. X- and Y-axis that are scaled and labeled iii. Labeled gridlines iv. Consecutive and connected data points, v. Legend for data points (when more than one type is used), and vi. Phase lines and labels for changes (i.e., programmatic, environmental, medical, and/or medication changes) b) Visual analysis that includes description of the level, trend, and variability of each behavior along with discussion related to programmatic, environmental, medical, and/or medication changes c) Future (planned) implementation must be described and include any barriers that need to be addressed (e.g., inaccurate implementation, incomplete data collection, etc.), and any changes that need to be made to the procedures based on lack of progress or deteriorating performance, and If fidelity procedures reveal that the BSP is being properly implemented and data properly collected, yet no progress is observed for the problem behavior, replacement behavior, or desired behavior for 3 consecutive months, then the Functional Assessment and its summary must be revisited with input from program implementers to determine the benefits modifying or augmenting BSP procedures or enhancing DSP training	is acceptable as long as the color copies are available to all members of the support team. b) The progress note should describe these items related to the desired outcome in the objective. c) The progress note should describe these items related to the desired outcome in the objective. May in some cases be "N/A". When "N/A" an explanation is needed. d) This would be documented by a dated, titled meeting sign- in sheet identifying the person, the reason(s) for lack of progress, and the revisions to BSP procedures that are to be implemented and DSP(s) to be trained for the revision, or justification for no revision. If this is not applicable to the case reviewed then "N/A" with explanation is sufficient. Signature sheets must be in the file. Note: If the fidelity procedures reveal that the BSP is not being properly implemented or data are not being properly collected, then re-training of the DSP(s) is sufficient, and no team meetings or plan modifications are required. Source: Residential Habilitation Standards
RS2-07	When psychotropic medication is given to address problem behavior that poses a significant risk to the person (i.e., self-injury), others (i.e., physical aggression) or the environment (i.e., property destruction) a Behavior Support Plan that addresses the specific behaviors for which the medication is given must be present.	A Behavior Support Plan (BSP) is not required when documentation/ data clearly indicates that the person is not exhibiting behavior that poses significant risk. A BSP is not required when evidence supports that the person has reached the lowest effective dosage based on data. Source: 600-05-DD
RS2-08	As needed by the person, but at least quarterly, psychotropic medications and the BSP are reviewed by the prescribing physician, the professional responsible for behavioral interventions, and support team.	Source: 600-05-DD
RS2-09	The specific behaviors/psychiatric symptoms targeted for change by the use of the Psychotropic medication are clearly noted.	Source: 600-05-DD
RS2-10	The Psychotropic Drug Review process provides for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence to the contrary is present.	Source: 600-05-DD
RS2-11	Consent for health care or restrictive interventions is obtained in accordance with 535-07-DD.	Source: 535-07-DD
RS2-12	When prescribed anti-psychotic medication or other medication(s) associated with Tardive Dyskinesia, monitoring is conducted.	Note: If medication associated with Tardive Dyskinesia is prescribed at the time of admission, a baseline T.D. score is obtained within one month. Source: 603-01-DD

RS2-13	Restraints are employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible.	Source documents: 567-04-DD and 600-05-DD.
DS1	**Day Services** **A"DDSN Day Service" includes Employment-Group Services through a Mobile Work Crew or Enclave, Career Preparation Community Service, Day Activity, or Support Center.** ***With the exception of Employment–Individual (See D2 Indicators)**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
DS1-01	After acceptance into service but prior to the first day of attendance in a DDSN Day Service, a preliminary plan must be developed that outlines the care and supervision to be provided.	Source: Day Services Standards
DS1-02	On the first day of attendance in a DDSN Day Service, the preliminary plan must be implemented. OBSERVATION: The interventions in the plan are implemented.	Source: Day Services Standards
DS1-03 R	**Within thirty (30) calendar days of the first day of attendance in a DDSN Day Service and annually thereafter, an assessment will be completed.**	Source: Day Services Standards
DS1-04 R	**The assessment identifies the:** **(1) abilities / strengths,** **(2) interests / preferences and** **(3) Needs of the consumer.**	Source: Day Services Standards
DS1-05 R	**Based on the results of the assessment, within thirty (30) calendar days of the first day of attendance and within 365 days thereafter, a plan is developed with input from the consumer and/or his/her legal guardian.**	Source: Day Services Standards
DS1-06 R	**The plan must include:** **a) A description of the interventions to be provided including time limited and measurable goals/objectives when the consumer participates in Employment - Group Services, Career Preparation, Community Services, and/or Day Activity.** **b) or, a description of the care and assistance to be provided when the consumer participates in Support Center.**	Source: Day Services Standards
DS1-07	The plan must include a description of the type and frequency of supervision to be provided.	Source: Day Services Standards and DDSN Directive 510-01-DD
DS1-08	For Support Center Services, the plan must include a description of the kinds of activities in which the consumer is interested or prefers to participate.	Goals and objectives are not required for Support Center Services. Note: This Indicator is N/A for all other Day Services. Source: Day Services Standards
DS1-09 R	**The interventions in the plan must support the provision of the DDSN Day Service(s) as defined in the standards.**	Source: Day Services Standards
DS1-10	As soon as the plan is developed, it must be implemented.	Source: Day Services Standards
DS1-11 R	**Data must be collected as specified in the plan and must be sufficient to support the implementation of the plan for each unit of service reported.**	Source: Day Services Standards

DS1-12	At least monthly, the plan is monitored by the Program Director or his/her designee to determine its effectiveness.	Source: Day Services Standards
DS1-13 R	**The plan is amended when significant changes to the plan are necessary.**	NOTE: Amendments to paper plans must be made using a separate form identified as a plan amendment, indicating the date of the amendment, the name and date of birth, the reason for the amendment, and description of how the plan is being amended. Plans developed in Therap's ISP Programs do not require a paper amendment form but should reflect the reason for the change to the ISP Program. Source: Day Services Standards
DS1-14	Restraints are employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible.	Source: 567-04-DD and 600-05-DD
DS2	**Employment-Individual Placement**	***Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.***
DS2-01 R	**A comprehensive vocational service assessment that is appropriate for the authorized service is completed within 30 calendar days of admission/enrollment in the service which is to be provided at a 1:1 staffing ratio.**	Source: Employment Services Standards
DS2-02 R	**An individual plan of employment is developed within 30 calendar days of admission/ enrollment.**	Source: Employment Services Standards
DS2-03 R	**The record will contain notations that show evidence of monitoring and evaluation of progress.**	Source: Employment Services Standards
DS2-04	Individualized, on-the-job instruction and needed and wanted supports are being provided in a nonintrusive method at a 1:1 staffing ratio.	Source: Employment Services Standards
DS2-05	Long-term support plans are identified in the individual plan of employment and contact with the consumer is maintained monthly at a 1:1 staffing ratio.	Source: Employment Services Standards
DS2-06	An exit interview is conducted when a consumer no longer wants the supports, relocates, chooses another provider for supports, enrolls in a nursing home, moves into a correctional facility, or refuses to cooperate with the terms listed in the Statement of Understanding Rights and Responsibilities.	An exit interview must be conducted prior to termination of Employment Services/Individual Placement. A signature must be secured by the individual, if at all possible. If a signature is not secured, a notation as to why the signature was not secured should be made. Source: Employment Services Standards

EARLY INTERVENTION INDICATORS & GUIDANCE

Review Year July 2018 through June 2019

EI	Early Intervention	*Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.*
EI-01	Written Prior Notice is given to the family prior to six-month update and annual IFSP.	**Not Applicable to DDSN Only** Source: IDEA, BabyNet Manual
EI-02	Written Prior Notice is given to the family prior to a formal change review of the IFSP.	**Not Applicable to DDSN Only** Source: IDEA, BabyNet Manual
EI-03	The Parent/Caregiver is provided a copy of the Plan annually and at the 6 month review. **DDSN only** – The Parent/Caregiver is provided a copy of the Plan annually and at the 6 month review within 10 days of completion.	Source: BabyNet Manual, DDSN EI Manual
EI-04 R	**Individualized Family Service Plan (IFSP)/Family Service Plan (FSP) is completed annually.**	If not met, document review period dates and date range out of compliance. IFSP must be current within one year, not to exceed 6 months from the last 6 month review, if applicable. The last page must be signed by the family and the EI. Source: IDEA, BabyNet Manual, DDSN EI Manual
EI-05	IFSP/FSP six-month review is completed within 6 months from the initial/annual review of the IFSP/FSP.	Source: IDEA, BabyNet Manual, DDSN EI Manual
EI-06	Documentation exists that the Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary (COS) screen in BRIDGES at entry.	**Not Applicable to DDSN Only** Source: IDEA, BabyNet Manual
EI-07	Documentation exists that the EI sought the input of other team members during the completion of the entry COS.	**Not Applicable to DDSN Only** Source: IDEA, BabyNet Manual
EI-08	Documentation exists that the Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary (COS), screen in BRIDGES, if applicable, at exit.	**Not Applicable to DDSN Only** Note: If the child received six months or less of services, the ECO exit will not be required. No exit required if provider did not complete entry. Source: IDEA, BabyNet Manual
EI-09	Documentation exists that the EI sought the input of other team members during the completion of the exit COS.	**Not Applicable to DDSN Only** Source: IDEA, BabyNet Manual
EI-10	IFSP/FSP includes current developmental information.	**Not Applicable to DDSN Only** Source: IDEA, BabyNet Manual, DDSN EI Manual
EI-11	All BabyNet services are listed on the “Planned Services” section of the IFSP, to include intensity, frequency, length, and a start and end date.	**Not Applicable to DDSN Only** Note: Must have an end date from plan to plan. Source: BabyNet Manual
EI-12	If the child's IFSP/FSP indicates the need for more than 4 hours per month of family training, the service notes indicate that information has been sent to the Office of Children's Services	Source: DDSN EI Manual

	for review. A Service Justification Form signed by staff from the Office of Children's Services must be present in the file.	
EI-13	All needs that are documented on the child's IFSP are provided within 30 days of identification unless there was a child/parent driven reason why the service wasn't provided.	**Not Applicable to DDSN Only** If no provider available or the child is placed on a provider waiting list, EI should make monthly attempts to locate a provider. If monthly follow up is documented in services notes, do not cite. Delays in service provision at the request of the family should not be considered. Delays due to the inability to locate a family or their lack of attendance at scheduled appointments should not be considered. Source: BabyNet Manual
EI-14	Transition to other services or settings is coordinated.	Source: DDSN EI Manual, EI Services Provider Manual, BabyNet Manual
EI-15	The Transition referral is sent to the LEA by the time the child turned 2.6 years old.	**Not Applicable to DDSN Only** Source: EI Services Provider Manual, BabyNet Manual
EI-16	Transition Conference is held no later than 90 days prior to the child's third birthday.	**Not Applicable to DDSN Only** Source: EI Services Provider Manual, BabyNet Manual
EI-17	Outcomes/goals are based on identified needs and the team's concerns relating to the child's development.	Source: EI Services Provider Manual, BabyNet Manual, DDSN EI Manual
EI-18	Outcomes/goals are/have been addressed by the Early Interventionist.	Source: EI Services Provider Manual, BabyNet Manual, DDSN EI Manual
EI-19	Assessments are completed every 6 months or as often as changes warrant.	Source: EI Services Provider Manual, BabyNet Manual
EI-20 W	Family Training is provided according to the frequency determined by the team and as documented on the IFSP "Planned Services" section of the IFSP or the "Other Services" section of the FSP.	If the parent/caregiver cancels the visit the EI does NOT have to offer to make the visit up. Source: EI Services Provider Manual, BabyNet Manual, DDSN EI Manual
EI-21	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit.	Source: DDSN EI Manual
EI-22 W	Entries for Family Training visits include how parent/caregiver(s) participated in visit.	Source: DDSN EI Manual, EI Services Provider Manual
EI-23	Family Training activities should vary. Activities planned must be based on identified outcomes on the IFSP/FSP.	Source: DDSN EI Manual
EI-24	Family Training activities correspond to outcomes on the outcome/goal section on the IFSP/FSP.	Source: DDSN EI Manual, EI Services Provider Manual
EI-25	Time spent/reported preparing for a Family Training visit corresponds with the activity planned.	Source: DDSN EI Manual, EI Services Provider Manual
EI-26	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) the family is offered a choice of an alternate Early Interventionist.	Source: IDEA, BabyNet Manual, DDSN EI Manual
EI-27	Service Notes document why and how the Early Interventionist participated in meetings/ appointments on the child's behalf.	Source: DDSN EI Manual
EI-28	If applicable, documentation in service notes indicates that the case was closed.	Source: DDSN EI Manual
EI-29	Medical Necessity form is completed prior to any services being delivered and/or reported.	Source: EI Services Provider Manual
EI-30	Did the child receive more than 3 hours of FT/SC in any calendar month? (Except for the	Note: For Informational purposes only. Does not affect the

	months in which an initial plan, annual plan, or transition conference were held).	score.
EI-31 R	Service Agreement is signed and present in file once a need for a DDSN service has been identified.	**Not Applicable to BabyNet Only** Source: DDSN EI Manual
EI-32	The Choice of Early Intervention Provider is offered annually.	**Not Applicable to BabyNet Only** Source: DDSN EI Manual
EI-33	IFSP/FSP "Other Services" section reflects the amount, frequency and duration of services being received. For the IFSP, this section should reflect non-BabyNet services (Waiver, Family Support Funds, Respite, ABC, etc.). For the FSP, this section should reflect all current services.	**Not Applicable to BabyNet Only** Source: IDEA, BabyNet Manual, DDSN Manual
EI-34	**DDSN Only** – There is a signed Service Justification form in the file for any child 5 years of age or older being served in Early Intervention.	Source: DDSN EI Manual
EI-35	**DDSN Only** – For children who are seeking DDSN eligibility, and family training is identified as a need, the Early Interventionist has 45 days from the eligibility date to complete the FSP.	Source: DDSN EI Manual
EI-36	**DDSN Only** – When file is transferred from another Case Management /Family Training provider a new FSP is completed or the current plan is updated within 14 days.	Source: DDSN EI Manual
EI-37	**DDSN Only** – FSP includes current information relating to vision, hearing, medical and all areas of development to include health.	Source: DDSN EI Manual
EI-38	**DDSN Only** – If less than 2 hours per month of Family Training is identified on the FSP, there is an approved Service Justification Form in the file.	Source: DDSN EI Manual